Dr. Moler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

87600 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mary Elizabeth Barth

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Barth

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1858

8. AGE: Years	Months	Days	If less than one day
89	7	11	hrs. min.

9. Birthplace: Somerset Pa (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business

FATHER 12. Name: Ringold, Markel

13. Birthplace: Pa

MOTHER 14. Maiden name: Dont Know

15. Birthplace: Dont Know

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1, 1947 (month) (day) (year)

Cemetery or crematory: Sant George church

Location: Mount Savage Md

18. Funeral director: John E Wolford

Address: Cumberland Md

19. Oct 30 19 47 W. L. Beauty, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28, 19 47, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 5 1945 to Sept. 27 1947, and that I last saw h alive on Sept. 27 1947.

	DURATION
Immediate cause of death: Pneumonia	
Due to: Cardiovascular Disease	6 Yrs.
Due to: Fall down steps.	
Other conditions: Lacerations of face and hands.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9/24/47

Where did injury occur? Mt. Savage (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fall Injured at work? No

23. SIGNATURE: R. M. Mosley M. D. or other

Address: Cumberland Md Date signed: 10/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

S 07609
Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: S. Carolina County:

City or town: North Charleston, S. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 A Liberty (If rural, give LOCATION) Park

2.(a) If veteran, name war: V

3. (a) FULL NAME Mary F. Dillon Bozard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Bozard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5th. 1922

8. AGE: Years 25 | Months 1 | Days 19 | If less than one day: hrs. min.

9. Birthplace: Berkley Co. South Carolina
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Wm. Dillon
13. Birthplace: Berkley Co. S. C.

MOTHER
14. Maiden name: Lassy Viola Dill
15. Birthplace: Berkley Co. S. C.

16. Informant: Mr. John W. Bozard
Address: Richardville, Berkley, S. Carolina

17. Remoral (Burial, cremation, or removal. Which?) Date thereof 9-27-1947 (month) (day) (year)

Cemetery or crematory: Bridgewater Cemetery

Location: Berkley Co. Charleston, S. C.

18. Funeral director: Joseph Dozier

Address: Frostburg, Md.

19. 9-24 1947 Mrs. Nancy N. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1947 to Sept 24 1947 and that I last saw her alive on Sept 23 1947

Immediate cause of death	DURATION
Streptococcus Septicemia	9 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D.
M. D. or other

Address: Frostburg Md. Date signed: 9-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

07602

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: 122 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 122 W. Main St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Kate L. J. Boode

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Solomon Boode

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 11 - 1871

8. AGE:

Years	Months	Days	If less than one day
75	11	20	hrs. min.

9. Birthplace: Borden Mines Alley, Md. (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER — 12. Name: Joseph Merritt

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Cinderella Grant

15. Birthplace: Virginia

16. Informant: Mrs. Nellie Engel Address: 152 Iron St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/1947 (month) (day) (year)

Cemetery or crematory: Boode Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Yaker

Address: Frostburg, Md.

19. 9-3 1947 Mrs. Hawley H. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1, 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Sept 1 1947 and that I last saw h[illegible] alive on Aug 22 1947

Immediate cause of death	DURATION
Carcinoma of Left Breast	9 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane M.D. M. D. or other

Address: Frostburg Md. Date signed: Sept 2 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

07603

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred: 410 North Waverly Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lafayette Ashby Carder

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Susan Carder

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 27 1864

8. AGE: Years	Months	Days	If less than one day
83	6	1	..... hrs. ..... min.

9. Birthplace: Romney, Hampshire Co, West Va

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER 12. Name: Abner Carder

FATHER 13. Birthplace: Three Churches, W. Va.

MOTHER 14. Maiden name: Emma Ellie

MOTHER 15. Birthplace: Romney, W. Va.

16. Informant: Fayette E. Carder

Address: 410 N Waverly Terr, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1,1947 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Romney, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Oct. 1, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 1947, at 4-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1947, to Sept. 28 1947

and that I last saw him alive on Sept. 1, 1947

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 yr.
Due to: Nephritis	4 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Clay E. Simmons M. D. or other

Address: Cumberland Date signed 9/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

07604

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Rural) Cresaptown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred: Cresaptown, Md (Rural)

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Rural) Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Harry Charles Cecil

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Stottlemyer

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	8	3	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: retired farmer

11. Industry or business: own

FATHER 12. Name: James Cecil

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Hanna

MOTHER 15. Birthplace: Maryland

16. Informant: Israel Cecil

Address: Cresaptown, Md

17. burial (Burial, cremation, or removal. Which?) Date thereof: October 3, 1947 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: E~~x~~ Eckhart Mines Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md

19. 10-1-47 (Date rec'd by registrar) 19 47 M. M. Summers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 19 47 at about 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw him alive Dead Sept. 29 19 47

Immediate cause of death	DURATION
Chronic myocarditis	several years
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	several years

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 9/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07605 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 da.
Hospital, institution, or street address where death occurred: Miners Hospital - Frostburg, Md.
How long in hospital or institution? 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: John Thomas Clark

3. (b) Social Security Number: 217-03-2034

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie Easter Clark
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1883

8. AGE:

Years	Months	Days	If less than one day
63	8	22	..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business: G. L. Coal Co. mine

FATHER
12. Name: John Thomas Clark
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary J. Platter
15. Birthplace: Lonaconing, Md.

16. Informant: Robert Clark
Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 1947 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

18. 9-13 19 47 Mrs. Nancy V. Poe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1947, to Sept 12 1947
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Skull Fracture	
Crushed Chest	
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Medical Examiners Case.

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Sept 11, 1947
Where did injury occur: Lonaconing, Allegany Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where): Industry
Means of injury: Mine Cave in Injured at work? yes.

23. SIGNATURE: Benedict Skitarelic M.D.
M. D. or other
Address: Memorial Hospital Date signed: 9/12/47

DRS. W.F.WILLIAMS

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124 C

CERTIFICATE OF DEATH

67606

Reg. Dist. No. 4

M

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County ~~GARRETT~~ Grant
City or town PETERSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. PEARL CRIPPEN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife AMOS CRIPPEN
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 19, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	23	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation HOUSEWORK
11. Industry or business

FATHER
12. Name CORNELIUS King
13. Birthplace PENNA.

MOTHER
14. Maiden name ESTHER ODARD
15. Birthplace PENNA.

16. Informant ELEANOR MOOMAN
Address PETERSBURG, W.VA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13 1947 (month) (day) (year)
Cemetery or crematory Maple Hill Cem
Location Petersburg, W.Va.
18. Funeral director P.C. Thrush & Son
Address Moorefield, W.Va.

19. Sept. 13 1947 (Date rec'd by registrar) W.R. Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 12, 1947 19 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4, 1947 19 to Sept. 12, 1947 19
and that I last saw her alive on September 11, 1947
Immediate cause of death Uremia Acidosis

	DURATION
Due to Diabetic Syndrome	
Due to Massive Intestinal Hemorrhage	
Other conditions	
Operation Yes	

(Include pregnancy within 3 months of death)
Major findings of operation September Hemorrhage
Was tissue removed for examination? Yes Date of operation
Autopsy? No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C.H. Hawkins M. D. or other
Address Cumberland Md Date signed 9-12-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr R. W. Reeves
q/a Westernport, Md

076067

CERTIFICATE OF DEATH

Reg. Diat. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Reeves Clinic
How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 80 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MICHAEL JOSEPH DAILEY

3.(b) Social Security Number: 214-10-3340

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Whitev	Married

6.(b) Name of husband or wife: Katherine Getty Dailey
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): October 18, 1902

8. AGE:

Years	Months	Days	If less than one day
44	11	8	...hrs. ...min.

8. Birthplace: Westernport, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Manager
11. Industry or business: Electric Light Company

FATHER
12. Name: John W; Dailey
13. Birthplace: Westernport, Maryland

MOTHER
14. Maiden name: Clara B. Kelly
15. Birthplace: Borden Shaft, Md.

16. Informant: Mrs Katherine Dailey
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 29, 1947 (month) (day) (year)
Cemetery or crematory: St Peters Cemetery
Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Md.

19. Sept 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 19 47 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/26/47 19.. to 9/26 19 47
and that I last saw h... alive on 9/26/47 19..

Immediate cause of death	DURATION
Acute Coronary Occlusion	20 Mins
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. W. Reeves M.D. M. D. or other
Address: Westernport Md Date signed: 9/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Rozum

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07608

46e

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County Allegany

City or town Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

Rt. 2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Carleton Deffenbaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Linna Robasson

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 12, 1879

8. AGE:

Years	Months	Days	If less than one day
68	6	10	...hrs. ...min.

9. Birthplace Town Creek (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own farm

FATHER 12. Name Denton Deffenbaugh

13. Birthplace Oldtown, Md.

MOTHER 14. Maiden name Eliza Hartsock

15. Birthplace Town Creek

16. Informant Mrs. Linna Deffenbaugh

Address Rt. 2, Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24 1947 (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location near Flintstone

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Sept. 24, 1947 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1947 at 1:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/10/47, 6/13/47 1947 to 9/22 1947 and that I last saw h... alive on 9/15/47. 1947

Immediate cause of death	DURATION
Carcinoma of rectum (right)	
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of ascending colon Date of op. 6/13/47

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joan R. Rozum M. D. M. D. or other

Address Cumberland Md. Date signed 9/23/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07609

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 yrs. 5 mos. 29 das.
Hospital, institution, or street address where death occurred:
Home) Island St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Island
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorothy Dodds

3.(b) Social Security Number: 216-05-5875

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 22, 1908

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
39	5	29		

9. Birthplace: Lonaconing, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Silk Winder
11. Industry or business: General Textile Co.

FATHER
12. Name: Jos. Dodds
13. Birthplace: Lonaconing Md

MOTHER
14. Maiden name: Marie Pendlebery
15. Birthplace: Midland, Md.

16. Informant: Robert Dodds
Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25 47 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: Dr. Eichhorn
Address: Lonaconing, Md.

19. Sept 25 1947 (Date rec'd by registrar) Jeanette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21 19 47 at 9.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw her alive Dead Sept 23 19 47

Immediate cause of death	DURATION
Subarachnoid hemorrhage spontaneous	45 minutes
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)
Address: Cumberland Md. Date signed: 9/22/47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07610

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred: High St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: High Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JENNIE DOLORES DOMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Russell Doman

6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): July 27, ~~1927~~ 1926

8. AGE: Years	Months	Days	If less than one day
21	1	19	..... hrs. ..... min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)

10. Usual occupation: - - - - - - - - - - - - - - -

11. Industry or business: - - - - - - - - - - - - - - -

FATHER

12. Name: George Moore

13. Birthplace: Barton, Md.

MOTHER

14. Maiden name: Olive Ritchie

15. Birthplace: Barton, Md.

16. Informant: Mrs George Moore

Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19, 1947 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Sept. 19 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16, 19 47 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 19 47, to Sept 16 19 47

and that I last saw h~~er~~ alive on Sept 14 19 47

	DURATION
Immediate cause of death: Chronic Nephritis	2 yr.
Due to:	
Due to:	
Other conditions: Anemia Anasarca	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas Reese M.D. M. D. or other

Address: Westernport, Md. Date signed: 9.18.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16 b

07611

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 mo.

Hospital, institution, or street address where death occurred: 70 Browning St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 Browning St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rose E. Dougherty

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John J. Dougherty

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 3 1887

8. AGE: Years 60 | Months 5 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Adam J. Fleckenstein

13. Birthplace Md.

MOTHER 14. Maiden name Rose Anne Corrigan

15. Birthplace Md.

16. Informant Joseph Dougherty

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 26 '47 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cumberland

18. Funeral director Louis Stein & Son

Address Cumberland

19. Sept. 25, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to Sept 23 1947 and that I last saw h.. alive on Sept 23 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Coronary Thrombosis Date of op. April 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Lozupone M.D. M. D. or other

Address Cumberland Md. Date signed 9/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Arthur Jones.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13b

07612

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, Institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution? 8 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Annie "Roby" Exline

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Exline

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? ? 1873

8. AGE: Years: 74 Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: Little Orleans Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: On home

FATHER — 12. Name: Jakob Roby

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Flora Zeigler

15. Birthplace: Unknown

16. Informant: Mrs. Marie Ratke

Address: 420 South St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1947 (month) (day) (year)

Cemetery or crematory: St. ~~Peters~~ Patricks Catholic Cemetery

Location: Little Orleans, Maryland

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Sept. 15, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Sept. 14 1947 and that I last saw her alive on Sept. 13 1947

Immediate cause of death	DURATION
Uremia	3 wks.
Due to Generalized arterio-sclerosis	10 yrs.
Due to Cardio renal vascular disease 11-24-47-QS.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 9-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07613

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

417 Pine Place

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 417 Pine Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bernard E. Giles

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nellie Beaty Giles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 21, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	25	..... hrs. ..... min.

9. Birthplace Paw Paw, West Virginia (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business own —

FATHER 12. Name William Giles

13. Birthplace England

MOTHER 14. Maiden name Martha Larkin

15. Birthplace West Virginia

16. Informant DuBois Giles

Address 417 Pine Place, Cumberland Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof September 18, 1947 (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md.

18. Funeral director Davis Stein, Inc.

Address Cumberland Md.

19. Sept. 18, 1947 (Date rec'd by registrar) Walter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Sept 16 1947 and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to —	
Due to Medical Examiner's Case	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Benedict Skitarelis M.D. M. D. or other

Address Mem. Hosp. Cumberland Date signed 9/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

Reg. Dist. No. 07614 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town 422 COLUMBIA ST.,
(If outside city or town limits, write RURAL and give nearest town)

Street No. CUMBERLAND
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ODESSA GUNNETTE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JAMES GUNNETTE

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) JULY 16, 1889

8. AGE: Years 58 | Months 1 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace PA, Blair County
(Town, county, and state)

10. Usual occupation HWFE

11. Industry or business

FATHER 12. Name ISAAC LYKENS

13. Birthplace PA

MOTHER 14. Maiden name ELIZABETH BOOKHAMMER

15. Birthplace PA

16. Informant James Gunnette

Address 422 Columbia St Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8 1947 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Sept. 8, 1947 (Date rec'd by registrar) Walter L. Fauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 6, 1947 at 10:51 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to Sept. 6 1947

and that I last saw her alive on 9-6- 1947

	DURATION
Immediate cause of death: Chronic interstitial cystitis with	5-10 years
Due to: rupture of bladder + urinary extravasation in	
Due to: peri-vesical tissues	
Other conditions: Chronic nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M.D.
M. D. or other

Address Cumberland, Md. Date signed 9-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07615

93d

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or Street address where death occurred:

Munro Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Lonaconing Box 42

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. No 2 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mabel E. Trimble Warden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Chas. E. Warden

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Mar. 17th., 1882

8. AGE: Years 65 | Months 5 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace Mt. Savage, Allegany, Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Geo. E. Trimble

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Informant Robert C. Warden

15. Birthplace Unknown

Address R.F.D. No 2 Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-25-1947 (month) (day) (year)

Cemetery or crematory Potters Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Baker

Address Frostburg, Md.

19. 9-23 1947 (Date rec'd by registrar) Mrs. Nancy N. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 1947, to Sept. 23 1947 and that I last saw her alive on September 22 1947.

Immediate cause of death	DURATION
Chronic myocarditis	6 mos.
Due to Mal-nutrition.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of

Where did injury occur? (City or town) X (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other

Address Frostburg, Md. Date signed 9/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

119a

07616

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 30 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 179 W. Mechanic

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elaina Kay Harris

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1946

8. AGE: Years 1 Months 1 Days 14 If less than one day hrs. min.

9. Birthplace Frostburg Allegany, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George Harris

13. Birthplace Eckhart Md.

MOTHER 14. Maiden name Helen Frans

15. Birthplace Dayton, Ohio

16. Informant George Harris

Address Frostburg Md.

17. Burial Date thereof 9-15-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director J. R. J. Durst

Address Frostburg Md.

19. 9-16 1947 Mrs. Nancy N. Rae

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1947 at 6.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/11 1947 to 9/12 1947 and that I last saw h.. alive on 9/12 1947

Immediate cause of death	DURATION
(1) Lobular Pneumonia	3 d.
(2) Convulsions	12 hrs
Due to Toxemia	
(3) Enteritis	3 d.
Due to Aspiratory infection	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Frank T. Durst M.D.

M. D. or other

Address 59 E. Main St. Frostburg Date signed 9/16/47

Within corporate limits

DR. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07617

156a

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 135 BEDFORD STREET
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MR. LAWRENCE HARVEY

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SEPARATED

6.(b) Name of husband or wife: THOMAS, SELENA
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): March 25, 1918

8. AGE: Years	Months	Days	If less than one day
30 29	5	22	..... hrs. ..... min.

9. Birthplace: Derby, England (Town, county and state)
10. Usual occupation: Salesman
11. Industry or business

FATHER
12. Name: HARRY H. HARVEY
13. Birthplace: Derby, England

MOTHER
14. Maiden name: Blanche Flint
15. Birthplace: Derby England

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20, 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. Sept. 20 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT 17, 1947, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1947 to Sept 17 1947 and that I last saw h. alive on dead 19.....

Immediate cause of death	DURATION
Skull fracture	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ~~Skull fracture~~ Date of op.:
Autopsy results: Skull fracture
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Sept 17 1947
Where did injury occur? Cumberland, Alleg. Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public place.
Means of injury: Fall down steps Injured at work?

23. SIGNATURE: Benedict Skotarelic M.D. M. D. or other
Address: R 2 Cumberland, Md. Date signed: Sept 20, 1947

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

58C

07618 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

519 Pine Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 519 Pine Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arlie Regenald Hedrick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1931

8. AGE: Years	Months	Days	If less than one day
16	1	6	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER 12. Name: Lemeul P. Hedrick

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Josephine Hymes

15. Birthplace: Penna.

16. Informant: Mr. Lemuel Hedrick

Address: 519 Pine Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 13, 1947 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Sept. 13 1947 (Date rec'd by registrar) W. R. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1947, at 8:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947, to Sept 10 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Rheumatic endocarditis	7 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Medical Examiner

23. SIGNATURE: Benedict Skotarski M.D
M. D. or other

Address: Memorial Hosp. Cumberland Date signed: 9/10/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07619

81a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County COUNTY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 59 OFFUTT ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EMMETT A HENRY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/26/46

8. AGE: Years ~~1~~ | Months 11 | Days 26 | If less than one day hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name EMMETT HENRY
13. Birthplace W.VA

MOTHER
14. Maiden name ALICE BARB
15. Birthplace W.VA.

16. Informant Memorial Hospital
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4 1947 (month) (day) (year)
Cemetery or ~~crematory~~ Rig Cemetery
Location Rig. - Md.
18. Funeral director A. C. Ruckman
Address Cumberland, Md.

19. Sept. 3 1947 (Date rec'd by registrar) W. R. Fraunfelter, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1947 at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29 1947 to Sept 2 1947
and that I last saw h alive on Sept 2 1947

	DURATION
Immediate cause of death 1. Pneumonitis	3 wks.
Due to 2. Toxic Tuberculosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. W. Eleasondee M. D. or other
Address 126 Decatur St. Cumberland Md. Date signed 9/3/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48 E

07620

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
Clement Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Clement St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hattie Belle Hillyard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Roser Hillyard
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb. 20- 1873

8. AGE: Years	Months	Days	If less than one day
74	6	11	...hrs. ...min.

9. Birthplace: Winchester, Va.
(Town, county, and state)
10. Usual occupation: House
11. Industry or business: "

FATHER
12. Name: James H. Vance
13. Birthplace: Winchester, Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Boyd V. Hillyard
Address: Clement St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/47 (month) (day) (year)
Cemetery or crematory: Mount Hebron Cemetery
Location: Winchester, Va.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Sept. 3 1947 (Date rec'd by registrar) Walter R. Tracey, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 19 47 at 7.55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on Dead Sept. 1 19 47

Immediate cause of death	DURATION
carcinoma of the womb	about 1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other
Address Cumberland Md. Date signed 9-1-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct name if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 — 076210

Reg. Diat. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Church Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Henry Hines

3.(b) Social Security Number: 217-03-1607

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 17-1876

8. AGE: Years: 71 | Months: 8 | Days: 9 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Mt Savage - alleg - Md.

(Town, county, and state)

10. Usual occupation: machinist

11. Industry or business: Brick works

FATHER — 12. Name: Charles Hines

13. Birthplace: Wellesburg, Pa.

MOTHER — 14. Maiden name: Mary Ann Miller

15. Birthplace: Mt. Savage, Md

16. Informant: Edw. Hines

Address: Mt Savage, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29-1947 (month) (day) (year)

Cemetery or ~~Crematory~~: St. Patricks

Location: Mt. Savage. Md

18. Funeral director: J. J. Quinn

Address: Frostburg Md

19. Sept 28 1947 (Date rec'd by registrar) Dennis M. Dermody Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1947 at 2:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1947 to Sept. 26 1947 and that I last saw him alive on September 26 1947

Immediate cause of death	DURATION
Myocarditis	3 years
Due to: Vascular Hypertension	3 years
Moderate Arteria Sclerosis	
Due to:	
Other conditions: asthma	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: William E. Moseley M.D.

M. D. or other

Address: Mt Savage Md — Date signed: 9/26/1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07622

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Mt. Pleasant Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt. Pleasant Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: First World War

3.(a) FULL NAME: ROBERT HOLT HITCHINS

3.(b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Kathleen Hitchins

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): January 6, 1893

8. AGE: Years: 54 Months: 7 Days: 25 If less than one day: hrs. min.

9. Birthplace: Frostburg, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Architect

11. Industry or business

FATHER
12. Name: Joseph Hitchins,
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Matheney,
15. Birthplace: Maryland

16. Informant: Mrs. Kathleen Hitchins,
Address: Petersburg, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4, 1947 (month) (day) (year)
Cemetery or crematory: National Cemetery,
Location: Arlington, Va.

18. Funeral director: J. R. Durst,
Address: Frostburg, Md.

19. 9-3 1947 (Date rec'd by registrar) Mrs. Nancy K. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1947, at 2 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939 19.., to Sept 2 1947
and that I last saw h..m alive on aug 30 1947

	DURATION
Immediate cause of death: acute Cardiac Dilatation	sudden
Due to: Chronic myocarditis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W O M Lane M D M. D. or other
Address: Frostburg Md Date signed 9-3-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

07623

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 361 Bedford Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM C. HIX

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Hattie Miller Hix

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 7, 1854

8. AGE: Years	Months	Days	If less than one day
93	1	28	____ hrs. ____ min.

9. Birthplace: Bedford, Missouri
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Chattie De nnison

Address: 361 Bedfors St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 7, 1947 (month) (day) (year)

Cemetery or crematory: Bier Cemetery

Location: Rawlings, Maryland

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 7 1947 (Date rec'd by registrar) Winter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5, 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1947 to Sept. 5 1947 and that I last saw h[illegible] alive on Sept. 4 1947

Immediate cause of death	DURATION
Myocardial Failure	2 wks
Due to Chronic Myocarditis	15 yrs
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 9-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

07624

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Diat. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred: Mt. Savage, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edna Cornelia Roenschell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Darry Roenschell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17th, 1869

8. AGE:

Years	Months	Days	If less than one day
78	0	13	..... hrs. ..... min.

9. Birthplace: Matthias, W. Va. (town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Nathan Yeager

13. Birthplace: Shenandoah, Va.

MOTHER

14. Maiden name: Eliza Bradley

15. Birthplace: Matthias, W. Va.

16. Informant: C. C. Yeager Md

Address 505 Frenay Ave. Cumb.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-4-1947 (month) (day) (year)

Cemetery or crematory: Methodist Cem.

Location: Mt. Savage Md.

18. Funeral director: Daniel Dailey

Address: Frostburg, Md.

19. Oct 2- 1947 (Date rec'd by registrar) Norman M. Dermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1947, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 25 1947, to Sept. 30th 1947 and that I last saw h[illegible] alive on September 30th 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 week
Due to: Vascular Hypertension & Arteriosclerosis.	Several years.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William E. Mosley M.D. M. D. or other

Address: Mt. Savage Md. Date signed: 10-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07625

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
State Street

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: State Street
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Caroline Cutler Luskosh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Luskosh

6.(c) If alive, give age: 6 years

7. Birth date of deceased (mo., day, yr.): Sept 11, 1853

8. AGE:

Years	Months	Days	If less than one day
94	0	6	hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

MOTHER FATHER

12. Name: Henry Cutler

13. Birthplace: Germany

14. Maiden name: Rebecca Helmes

15. Birthplace: Unknown

16. Informant: Mrs. Arthur Poland

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19, 1947 (month) (day) (year)

Cemetery or crematory: Old Caney Cemetery

Location: Lonaconing, Md.

18. Funeral director: Mr. Eichhorn

Address: Lonaconing Md

19. Sept 19 1947 (Date rec'd by registrar) Jeanette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1947, to Sept 17 1947

and that I last saw h alive on 19

Immediate cause of death: Arteriosclerotic cardio-vascular disease — DURATION

Due to: —

Due to: —

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Medical Examiner's Case

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Benedict Skatarelic M.D.
M. D. or other

Address: Mem. Hosp. Cumberland Md Date signed 9/17/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 07626 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs.
Hospital, institution, or street address where death occurred:
741 Maryland Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 741 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Miss Regina M. Jones (Jean Jones)

3.(b) Social Security Number 213-12 9876

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7 1920

8. AGE: Years 27 Months 5 Days — If less than one day hrs. min.

9. Birthplace Piedmont W. Va.
(Town, county, and state)

10. Usual occupation office worker

11. Industry or business U S Tire Co.

FATHER
12. Name Frank B Jones
13. Birthplace Newburg W. Va.

MOTHER
14. Maiden name Catherine Donnelly
15. Birthplace Pa.

16. Informant Frank B Jones.
Address Cumberland

17. Buried Date thereof Sept 10, 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Patricks Cem.
Location Cumberland

18. Funeral director Lynn Stein, Inc.
Address Cumberland Md.

19. Sept. 9 1947 U.R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1947 at 11.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw her alive Dead Sept. 7 1947.

Immediate cause of death: Coronary occlusion of the left coronary artery — DURATION: gradual about 6 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or Coroner
Address Cumberland, Md. Date signed Sept 7/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

07627

Reg. Diat. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Green Ridge Station (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Green Ridge Station, Md.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Green Ridge Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Little Orleans, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emanuel Keefer

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Ida Snyder Keefer
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): June 20, 1871
8. AGE: Years: 76 Months: 3 Days: 3 If less than one day: hrs. min.
9. Birthplace: Pearre, Allegany, Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Michael Keefer
13. Birthplace: Penna.

MOTHER
14. Maiden name: Hannah Potts
15. Birthplace: Maryland

16. Informant: Mrs. Ida Keefer
Address: Greene Ridge Station, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27, 1947 (month) (day) (year)
Cemetery or crematory: St. Patricks Cem.
Location: Little Orleans, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Sept 26 1947 (Date rec'd by registrar) Mrs. E.A. Shanholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23 1947 at 5.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on Dead Sept. 23 1947

Immediate cause of death: Coronary occlusion — DURATION: at once
Due to: arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H.V. Deming M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 9/24/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07628

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred: 140 N. Mechanic St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 140 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Katherine Kirscher

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Isaac Kirscher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) about 1864

8. AGE: Years	Months	Days	If less than one day
83.	—	—	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housework.

11. Industry or business At Home

FATHER 12. Name Joseph Schwendauer

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Hannah ——

MOTHER 15. Birthplace Germany

16. Informant Mrs Eugene Landis

Address 114 Park St Cumberland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 30 47 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem.

Location Cumberland

18. Funeral director Long Stein & Orr

Address Cumberland

19. Sept. 29 1947 (Date rec'd by registrar) W. L. Beantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/46 19 to 9/27/47 19.

and that I last saw h alive on 9/27/47 19

Immediate cause of death	DURATION
Chr Myocarditis	5 yrs
Due to Arteriosclerosis	
Due to Senile	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Allegaman M.D.

M. D. or other

Address Date signed 9/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. R. W. Williams

Outside of City limits

07629

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: La Vale, Rt. #1 Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: La Vale, Md. - R.F.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: La Vale, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. # 1 Cumberland, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE KREITZBURG

3.(b) Social Security Number: 214-07-5142

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Mickey
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Oct. 19, 1897

8. AGE: Years	Months	Days	If less than one day
49	10	29	...hrs. ...min.

9. Birthplace: Eckhart, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Machinist Foreman
11. Industry or business: Celanese Corp. of America

FATHER
12. Name: Geo. H. Kreitzburg
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Griffith
15. Birthplace: Maryland

16. Informant: Mrs. Bertha Kreitzburg
Address: La Vale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1947 (month) (day) (year)
Cemetery or crematory: Hill Crest
Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Sept. 22, 1947 (Date rec'd by registrar) W. R. Fraunfelter, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18, 1947 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3 1946, to Sept. 18 1947
and that I last saw h... alive on September 18 1947

Immediate cause of death	DURATION
congestive heart failure	1/2 year
Due to Uremia myocarditi	1/2 year
Due to coronary thrombosis	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. Blevins MD
M. D. or other
Address: 55 Green St. Date signed: 9-19-47

Within corporate limits

8415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bonita Susan Lankard

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1947

8. AGE: Years	Months	Days	If less than one day
	4	22	hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name David E. Lankard
13. Birthplace Alexandria, ~~Va.~~ Pa.

MOTHER
14. Maiden name Florence Davidson
15. Birthplace Bedford, Pa.

16. Informant David E. Lankard

Address Rt. 1, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27, 1947 (month) (day) (year)

Cemetery or crematory Bedford Cemetery

Location Bedford, Pa.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Sept 26, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1947, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1947 to Sept. 25 1947 and that I last saw h[illegible] alive on Sept. 24 1947

Immediate cause of death	DURATION
pulmonia, bronchial	1 week
Due to	
Due to	
Other conditions partial obstruction of the upper air passages (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth Bruce, M.D.
M. D. or other

Address La Vale, Md. Date signed 9/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7d 07630 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 7 hours

Hospital, institution, or street address where death occurred:
Cumberland City Jail

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. no home
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Odie Arthur Largent

3.(b) Social Security Number: 212-12-8073

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Divorced

6.(b) Name of husband or wife: Jessie Hoffman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? ? 1897

8. AGE: Years	Months	Days	If less than one day
50	>	>	hrs. min.

9. Birthplace: Paw Paw, Morgan, W.Va.
(Town, county, and state)

10. Usual occupation: Paper Hanger

11. Industry or business: Self Employed

FATHER
12. Name: George W. Largent
13. Birthplace: Forks of Capon, W.Va.

MOTHER
14. Maiden name: Laura Jane Bucy
15. Birthplace: Flintstone, Md.

16. Informant: Clyde E. Largent
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5, 1947 (month) (day) (year)

Cemetery or crematory: German Beneficial

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Sept. 5, 1947 (Date rec'd by registrar) Winter R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 19 47 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Sept. 3 19 47

Immediate cause of death	DURATION
Chronic alcoholism	13 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed 9-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07631

DR W. F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? TEN DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? TEN DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ~~ALLEGANY~~ Garrett
City or town JENNINGS MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. JENNINGS MD
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Winland
MARX LAYMAN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ROSIE CUNNINGHAM
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1873

8. AGE: Years	Months	Days	If less than one day
73	~~DEC~~ 9	~~28~~ 1	...hrs. ...min.

9. Birthplace Milltown Garrett County, Md.
(Town, county, and state)
10. Usual occupation RETIRED Farmer
11. Industry or business

FATHER
12. Name LAYMAN, ANTHONY
13. Birthplace MARYLAND

MOTHER
14. Maiden name COLEMAN, ELIZABETH
15. Birthplace MARYLAND

16. Informant Memorial Hosp.
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1947 (month) (day) (year)
Cemetery or crematory Mt. Zion Cem.
Location Mt. Zion, Grantsville, Md. Garrett
16. Funeral director William Weinberg Sons
Address Grantsville, Md. Garrett Co.
19. Oct. 1, 1947 (Date rec'd by registrar) W. R. Beasley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 29 1947, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1947, to Sept 29 1947
and that I last saw h... alive on 9/29/47 1947

Immediate cause of death	DURATION
Chr. Myocarditis	10 yrs.
Due to	
Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE D. W. Williams M.D.
M. D. or other
Address Cumberland Date signed 9/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

Within corporate limits

Jacobson (1454)

07632

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1809 BEDFORD ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JOHN LESTER

3.(b) Social Security Number 705-05-1774

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
MALE	WHITE	MSRRIED

6.(b) Name of husband or wife ELIZABETH BEATTY

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) APRIL 2, 1878

8. AGE: Years	Months	Days	If less than one day
69	5	5	...hrs. ...min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation RETIRED Signal Supervisor

11. Industry or business B. & O. Railroad Co.

FATHER
12. Name CHARLES LESTER
13. Birthplace DELAWARE

MOTHER
14. Maiden name ELIZABETH ITNER
15. Birthplace MARYLAND

18. Informant Mrs. Elizabeth Lester
Address 1809 Bedford St. Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10, 1947 (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director William H. Kegler

Address Cumberland, Md.

19. Sept. 10, 1947 (Date rec'd by registrar) Wister R. Faute, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2, 1947 to Sept 7, 1947 and that I last saw him alive on Sept 7, 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	
Due to Coronary Artery Disease Arteriosclerosis	5 yrs
Due to Acute Myocardial Infarction	
Other conditions Arteriosclerosis, Abdominal Aorta Pulmonary Emphysema	

(Include pregnancy within 3 months of death)

Major findings of operations Negative exploration 9/4/47 abd

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M.D.
M. D. or Coroner

Address 50 Prospect Pl. Date signed 9/10/47

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of year of birth is shown on G 112 10/8/47

07633

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 245 Welsh Hill

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 245 Welsh Hill

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Wm. Lewis

3.(b) Social Security Number: 220-10-4470

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Fannie L. Lewis

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Dec. 28-1868 1867

8. AGE: Years: 79 Months: 8 Days: 29 If less than one day: hrs. min.

9. Birthplace: Borden Shaft - alleg - md. (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Felgners plant

FATHER 12. Name: John Lewis

13. Birthplace: Wales

MOTHER 14. Maiden name: Margret ? ?

15. Birthplace: Wales

16. Informant: Mrs Geo. Mc Luckie

Address: Frostburg, md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 29-1947 (month) (day) (year)

Cemetery or crematory: allegany

Location: Frostburg, md.

18. Funeral director: J. J. Hurst

Address: Frostburg md

19. 9-29 1947 (Date rec'd by registror) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1946, to Sept. 26 1947 and that I last saw him alive on Sept. 26 1947

Immediate cause of death: Diabetes — DURATION: 2 years

Due to: Femoral thrombosis — 5 weeks

Due to: Dry gangrene Left Leg

Other conditions: Coronary thrombosis

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W D M Lane M.D. (M. D. or other)

Address: Frostburg Md Date signed: 9-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07634 8

Reg. Dist. No.

CERTIFICATE OF DEATH

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, Institution, or street address where death occurred: Charlestown St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: Charlestown (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Mary C Laird Love

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Isaac Love

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	2	..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegany Co. Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

MOTHER FATHER

12. Name: Joseph Laird

13. Birthplace: Scotland

MOTHER

14. Maiden name: Annie Thompson

15. Birthplace: Unknown

16. Informant: Mrs Isaac Love

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20, 47 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing Md

19. 9/20 19 47 (Date rec'd by registrar) Jeanette M Pool Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/17, 19 47, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/17 19 47 to — 19 —

and that I last saw h.e.r. alive on 9/17/47 19 —

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: ?	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Paul Eugene Drey MD (M. D. or other)

Address: Lonaconing Md Date signed: 9/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07635

Reg. Diat. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

River Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: River Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JOSLPH THOMAS MASON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jeretha Alice Mason

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): February 18, 1874

8. AGE:

Years	Months	Days	If less than one day
73	7	5	hrs. min.

9. Birthplace: Winchester, Frederick, Virginia

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: W. Va. Pulp and Paper Co.

FATHER

12. Name: J. Martin Mason

13. Birthplace: Winchester, Virginia

MOTHER

14. Maiden name: Marie K. Sirbaugh

15. Birthplace: Winchester, Va.

16. Informant: Mrs. J. A. Mason

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 26, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Sept. 26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 19 47 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 1st 19[illegible] to Sept 23 19 47

and that I last saw him alive on Sept 23 19 47

Immediate cause of death

Carcinoma of Stomach — DURATION: 6 mo

Due to

Due to

Other conditions Arteriosclerosis — 4 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James H. Johnston M.D. M. D. or Coroner

Address: Piedmont, W. Va. Date signed: 9-27-47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

07636

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Mineral
City or town: Keyser Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Victor Emanuel Mastrodomenico

3.(b) Social Security Number: 215-20-6617

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1926

8. AGE:

Years	Months	Days	If less than one day
21	4	11	hrs. min.

9. Birthplace: McCoole, Maryland (Town, county, and state)
10. Usual occupation: Twisting Block #1
11. Industry or business: Celanese Plant

FATHER
12. Name: Antonio Mastrodomenico
13. Birthplace: Italy

MOTHER
14. Maiden name: Pauline Scarpone
15. Birthplace: Italy

16. Informant: Antonio Mastrodomenico
Address: R.F.D. #3, Keyser, W. Va.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept. 19, 1947 (month) (day) (year)
Cemetery or crematory: St. Thomas
Location: Keyser, W. Va.
18. Funeral director: N. L. Rogers
Address: Keyser, W. Va.
19. Sept 16, 1947 (Date rec'd by registrar) W. L. Fraunfelter, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16, 1947, to Sept 16, 1947 and that I last saw h alive on 19

Immediate cause of death	DURATION
Gunshot wound of head.	
Due to	
Due to	
Other conditions: Medical Examiners Case	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 9/14/47
Where did injury occur? Cumberland (City or town) alleg (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Gunshot Injured at work?

23. SIGNATURE: Benedict Statarelic M.D. (M. D. or other)
Address: Mem. Hosp. Cumberland Date signed: 9/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122 L

07637

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? Three Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town MIDLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. PARADISE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mc Cabe
MARY McGOWAN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FE MALE	WHITE	MARRIED

6.(b) Name of husband or wife KERXJOSEPH McGOWAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~Unk~~ June 18, 1881

8. AGE: Years 66 | Months 3 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Moscow, MARYLAND, Alleg. County
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER
12. Name JAMES McCABE
13. Birthplace IRELAND

MOTHER
14. Maiden name BRIDGETT HOGAN
15. Birthplace IRELAND

16. Informant Mrs. Florence McCoskey Ernie
Address Doylestown, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27, 1947 (month) (day) (year)

Cemetery or crematory St. Michaels Cem.

Location Frostburg, Md.

18. Funeral director M. Erchhorn

Address Lonaconing, Md

19. Sept. 26, 1947 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 24 1947 at 1:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Sept 24 1947

and that I last saw her alive on Sept 22 1947

Immediate cause of death Intestinal obstruction — DURATION

Due to Malignancy Large Gut? —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE W. L. Frantz M. D. or other

Address Cumberland Md Date signed Sept 26

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

122a

07638

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, XXXX

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, Institution, or street address where death occurred:

231 Maryland Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 231 Maryland Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: DAVID FRANKLIN McINTOSH

3.(b) Social Security Number: 236-03-3986

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lessie Buckalew McIntosh

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 11, [redacted] 1884

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	2	1		

9. Birthplace: Hedgesville, Mineral, W. Va. (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER — 12. Name: George McIntosh

FATHER — 13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Marg S. Cook

MOTHER — 15. Birthplace: West Virginia

16. Informant: Lessie Buckalew McIntosh

Address: 231 Md Ave, Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 15, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Sept 15 1947 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1947 at 9:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1947 to Sept. 12 1947

and that I last saw h.i.m alive on Sept 12 1947

	DURATION
Immediate cause of death: Starvation	3 Weeks
Due to: Senility with reference to Senile Dementia	6 Months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Paul R. Wilson M.D. (M. D. or other)

Address: Piedmont W.Va. Date signed: Sept. 14, 1947

Within corporate limits
Dr Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

480

07639

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 218 Paca St.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 218 Paca St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY ELIZABETH MEEK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Gibson A. Meek
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Mar. 23, 1895

8. AGE: Years	Months	Days	If less than one day
52	5	7	...hrs. ...min.

9. Birthplace: Baird, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Charles Mulligan
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Rachael Hite
15. Birthplace: Maryland

16. Informant: Mr. Gibson A. Meek
Address: 218 Paca St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1947 (month) (day) (year)
Cemetery or crematory: S. S. Peter & Paul
Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Sept. 3, 1947 (Date rec'd by registrar) Walter L. Fraula M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1, 1947, at 7:20A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 1947 to Sept 1 1947 and that I last saw her alive on Sept 1 1947

Immediate cause of death: Carcinoma Cervix Uteri — DURATION: years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler M.D. M. D. or other
Address: 41 Grand St. Date signed: Sept 2, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c 07640

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: highway 55 about 1/4 mile from Clarysville Inn 2 miles east of Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Narrows Park, Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 40
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: David Gene Miller

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: (crossed out) child

6.(c) If alive, give age: 6 years

7. Birth date of deceased (mo., day, yr.): Dec 13, 1940

8. AGE: Years: 6 | Months: 9 | Days: 15 | If less than one day: ... hrs. ... min.

9. Birthplace: Cumberland, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: William Miller
13. Birthplace: Lonaconing, Md.

MOTHER
14. Maiden name: Irene Holmes
15. Birthplace: Lonaconing Md

16. Informant: Mrs. Betty Miller
Address: Narrows Park, Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 2 1947 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: J.N. Eichhorn

Address: Lonaconing, Md.

19. 9-30 1947 (Date rec'd by registrar) Mrs. Harvey L. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 1947 at 12.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on Dead Sept. 28 1947

Immediate cause of death	DURATION
Fracture 2nd cervical Veterbrae	
fracture of occipital bone	at
and puncture wound, & severe	once
concussion of brain	
Due to: Fell out of automobile	
and landed on head	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-28-47

Where did injury occur? Route 55-2 Mi. east of Frostburg Md. Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway 55

Means of injury: door opened and fell out of automobile Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V. Deming M.D. H.V. Deming MD
M. D. or other

Address: Cumberland Md. Date signed: 9/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits — R. F. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 8

07641 4

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town LONACONING
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MR. SAMPSON MUIR

3.(b) Social Security Number: 220-10-2304

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: CHARLOTTE BEAMER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JANUARY 15, 1887

8. AGE: Years	Months	Days	If less than one day
60	8	4	..... hrs. ..... min.

9. Birthplace: Moscow, MARYLAND, Allegany County
(Town, county, and state)

10. Usual occupation: MINER

11. Industry or business: Coal Mine

FATHER
12. Name: Michael Muir
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: JAMES W. MUIR
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22, 1947 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cem.
Location: Moscow, Md

18. Funeral director: E. Elsworth & Bosa
Address: Westernport Md

19. Sept. 19, 1947 (Date rec'd by registrar) W. R. Fauntz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 19, 1947 at 4:38 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 19 45 to Sept 19 19 47
and that I last saw h... alive on Sept 18 19 47

Immediate cause of death	DURATION
Coronary	24 hrs.
Due to, Chr. Nephritis	?
Due to, Chr. Nephritis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. M. Wilson M. D. or other
Address Lonaconing Md Date signed 9-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

07642

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [redacted]

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? About 2 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Bellevue St., (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clyde Mull

3. (b) Social Security Number 214-05-9581

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Iva Myrl Evans

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1900

8. AGE: Years	Months	Days	If less than one day
47	5	4	..... hrs. ..... min.

9. Birthplace Madley, Penna. (Town, county, and state)

10. Usual occupation Auto salesman

11. Industry or business Hare Auto Co.

FATHER — 12. Name Simon Mull

FATHER — 13. Birthplace Penna.

MOTHER — 14. Maiden name Lula Kennell

MOTHER — 15. Birthplace Penna.

16. Informant Mrs. Iva Mull

Address 5 Bellevue St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8, 1947 (month) (day) (year)

Cemetery or crematory Madley Cem.

Location Madley, Penna.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Sept. 8, 1947 (Date rec'd by registrar) White R. Fauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 19 47, at 8.30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..

and that I last saw him alive on Dead Sept. 5 19 47

Immediate cause of death	DURATION
Coronary occlusion	about 8 min.
Due to Cardiac hypertrophy	
Due to also coronary sclerosis	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H.V. Deming M.D. M. D. Mother

Address Cumberland, Md. Date signed 9/6/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

146 b

07643

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? about 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Spruce St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Norma Mulligan

3.(b) Social Security Number 215-14-6532

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 21. 1924

8. AGE:

Years	Months	Days	If less than one day
23	6	15	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business Restaurant

FATHER
12. Name Charles Rice
13. Birthplace Md.

MOTHER
14. Maiden name Ella [illegible] Mulligan
15. Birthplace W. Va.

16. Informant Mrs. Ella Rogan

Address 221 Spruce St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9, 1947 (month) (day) (year)

Cemetery or crematory St. Patricks

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Sept. 9 1947 W.R. Frantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947 at 9.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive Dead Sept. 6 1947

Immediate cause of death	DURATION
Exsanguination	
Due to premature seperation of placenta, bled profusely 3 times	
Due to during Aug. premature 7 mo. twins born dead Sept. 1st/47	
Other conditions Small portion retained placenta.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland, Md. Date signed Sept 7/47

Within corporate limits C. L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161c 07644

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND, County ALLEGANY
City or town FLINTSTONE (If outside city or town limits, write RURAL and give nearest town)
Street No. FLINTSTONE, MD. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
NAZELROD, BABY GIRL Evelyn Marie

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 25, 1947

8. AGE:	Years	Months	Days	If less than one day
	0	0	2	hrs. min.

9. Birthplace FLINTSTONE MD. Allegany Co. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name NAZELROD, WALTER
13. Birthplace W.VA. Peru

MOTHER
14. Maiden name STALLINGS, MAUDE
15. Birthplace MARYLAND, Oldtown

16. Informant Walter Nazelrod
Address Flintstone, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1947 (month) (day) (year)
Cemetery or crematory Mt. Tabor Methodist Cemetery
Location Spring Gap, Maryland.

19. Funeral director John J. Hafer
Address Cumberland, Md.

19. Sept 28, 1947 (Date rec'd by registrar) W. R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947 at 8:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1947 to Sept 27 1947 and that I last saw her alive on Sept 27 1947

Immediate cause of death	DURATION
Hemorrhage Newborn	
Due to Melena Neonatorum	2 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D. M. D. or other
Address Flintstone Md Date signed Sept 27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07645

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Beall St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lucy Treverton Odgers

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry Odgers
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 18, 1879

8. AGE: Years 68 | Months 3 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace: Yatesville, Bedford, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER
12. Name: William Treverton
13. Birthplace: Cornwall England

MOTHER
14. Maiden name: Mary Ann Sprague
15. Birthplace: Cornwall England

16. Informant: Harry Odgers
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5 1947 (month) (day) (year)
Cemetery or crematory: Everett Cemetery
Location: Everett Penna.

18. Funeral director: J. R. Durst
Address: Frostburg Md.

19. 9-4 1947 (Date rec'd by registrar) Mrs. Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1947, at 12:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1947, to September 3 1947 and that I last saw h. LT alive on September 2nd 1947.

	DURATION
Immediate cause of death: Acute myocarditis	6 days.
Due to: La grippe	2 wks.
Due to: X	
Other conditions: X	

(Include pregnancy within 3 months of death)

Major findings of operations: X
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? X (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other
Address: Frostburg, Md. Date signed 9/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr Wolverton

55a

07646

Reg. Dist. No. 6

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, Institution, or street address where death occurred: 145 Church St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 145 Church St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ALLIE HAZEL POLAND

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: - - - - - - - - - - - -

6.(c) If alive, give age - - Years

7. Birth date of deceased (mo., day, yr.): April 14, 1888

8. AGE: Years	Months	Days	If less than one day
59	5	1	hrs. min.

9. Birthplace: Moscow, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business: Junior High School

FATHER — 12. Name: James T. Poland

13. Birthplace: Moscow, Maryland

MOTHER — 14. Maiden name: Nora Guard

15. Birthplace: Shelbysport, Maryland

16. Informant: Heber Poland

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18, 1947 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Sept 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 19 47 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 19 47 to Sep 15 19 47

and that I last saw h er alive on Sep 14, 1947 19

Immediate cause of death	DURATION
Metastatic carcinoma of lung	6 mo.
Due to: Primary focus undetermined probably pelvis.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James H Wolverton Jr MD M. D. or other

Address: Piedmont W Va Date signed 9-17-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07647

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: Frostburg, R.D. #2 Frostburg Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. #2 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertha Mae Porter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Benjamin Porter

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) July 3rd 1883

8. AGE: Years 64 | Months 2 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace Barton Allegany Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Alex Lynch

13. Birthplace Barton, Md

MOTHER 14. Maiden name Carol Barnard

15. Birthplace Unknown

16. Informant Mr. Benjamin Porter

Address R.D. No 2 Frostburg, Md

17. Burial (Burial, cremation, or removal) Which? Data thereof 9-23-1947 (month) (day) (year)

Cemetery or crematory Porter Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Kaufman

Address Frostburg Md.

19. 9-22 1947 Mrs. Harvey N. Rice Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1947, to Sept 21 1947 and that I last saw h... ~~alive on~~ dead Sept 21, 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Med. Examiner's case

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benedict Skitarelic M.D.
M. D. or other

Address R2 Cumberland, Md Date signed 9/26/47

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

07648

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town ~~Rural~~ Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 6, Roberts Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Doris Elaine Rosenberger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 26, 1932

8. AGE: Years	Months	Days	If less than one day
15	5	24	..... hrs. ..... min.

9. Birthplace Grantsville, Md.

(Town, county, and state)

10. Usual occupation School

11. Industry or business

FATHER 12. Name Raymond Rosenberger

13. Birthplace New Rockford, N. Dak.

MOTHER 14. Maiden name Pearl M. Beachy

15. Birthplace Grantsville, Md.

16. Informant Raymond Rosenberger

Address Rt. 6, Cumberland, Md.

17. Burial Date thereof Sept. 23, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grantsville Cemetery

Location Grantsville, Maryland

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 23 1947 W. L. Lantz M. D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1947 at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1947, to Sept 20 1947 and that I last saw h.. on alive on dead Sept 20 1947

Immediate cause of death	DURATION
Skull fracture	
Intra-Cranial hemorrhage	
Due to	
Due to	
Other conditions Fracture of left ankle,	

(Include pregnancy within 3 months of death)

Major findings of operations Medical Examiner's Case Date of op.

Autopsy (yes or no)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 20, 1947

Where did injury occur? Robert's Place (City or town) Alleg. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route 220, Public Place

Means of injury Auto accident Injured at work? —

23. SIGNATURE Benedict Skotarelic M.D.

M. D. or other

Address Route #2 Cumberland Signed 9/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

07649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59-6-13

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Wills Creek Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Clara J. Rosenmerkel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: C. Ward Rosenmerkel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 15 1888

8. AGE: Years	Months	Days	If less than one day
59	6	13	..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER — 12. Name: John Henry Riggs

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Catherine Hammersmith

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Nelson W. Rosenmerkel

Address: 107 Wells Creek Ave. Cumberland Md

17. Interment (Burial, cremation, or removal. Which?) Date thereof October 1, 1947 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cemetery

Location: Cumberland, Md.

18. Funeral director: Lewis Stein Inc.

Address: Cumberland, Md.

19. Sept. 30 1947 (Date rec'd by registrar) W. R. Fraunfelter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1947, at 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24-1945 19.. to Sept. 28 1947 and that I last saw h.. alive on Sept. 28 1947

Immediate cause of death	DURATION
Carcinoma of sigmoid	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Sigmoid Date of op. 8/1947

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John K. Rozzell M.D. M. D. or other

Address Cumberland Md Date signed 9/29/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124a 07650

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

735 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 735 Fayette St.

(If rurel, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Philip F Schaffer

3. (b) Social Security Number 714-05-6583

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Stella Mc Kenzie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 15 1892

8. AGE: Years	Months	Days	If less than one day
54	11	8	..... hrs. ..... min.

9. Birthplace Rawlings, Allg Co. Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Wm. Schaffer

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Anna Schmidt

MOTHER 15. Birthplace Germany

16. Informant Mrs Anna Uhl

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 '47 (month) (day) (year)

Cemetery or crematory St. Peter & Paul Cem.

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland

19. Sept. 24, 1947 (Date rec'd by registrar) W.R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1947, to Sept 6 1947 and that I last saw h. alive on Sept 6 1947

	DURATION
Immediate cause of death Cirrhosis of the Liver	?
Due to Chronic alcoholism	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland, Md Date signed 9/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town La Vale

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank H. Schiller

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary M. Hoffman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? ? 1865 ?

8. AGE: Years 82 | Months ? | Days ? | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business own

FATHER 12. Name Unknown

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant Wilbert Nicholas

Address Route 5, Cresaptown Md

17. buried (Burial, cremation, or removal. Which?) Date thereof Sept. 8 1947 (month) (day) (year)

Cemetery or crematory St Luke's Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein Inc

Address Cumberland Md.

19. Sept 8, 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 31 1947, to Sept 4 1947 and that I last saw him on Sept 4 1947

	DURATION
Immediate cause of death: Chronic myocarditis	?
Due to: hypertrophy (cardiac)	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Deming M.D. M. D. or other

Address Cumberland Md Date signed 9-5-1947

07652

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr R. W. Reeves
94a Westernport, Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
Germen St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: German St
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # 1

3.(a) FULL NAME: WILLIAM McKINLEY SCHRAMM

3.(b) Social Security Number: XXXX 216-07-6755

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Schramm
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): November 2, 1896

8. AGE: Years	Months	Days	If less than one day
50	10	24	....hrs. ....min.

9. Birthplace: Barton, Allegany, Maryland (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine

FATHER
12. Name: Henry Schramm
13. Birthplace: Barton, Maryland

MOTHER
14. Maiden name: Elizabeth Schramm
15. Birthplace: Barton, Maryland

16. Informant: Mr. Charles Schramm
Address: Lonaconing, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept, 29, 1947 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Maryland
18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19. Sept 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 19 47 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/26/47 19.. to 9/26/47 19.. and that I last saw h.. alive on Dead 19/26/47 19..

Immediate cause of death	DURATION
Coronary Occlusion	sudden
Due to Myocardial Infarction	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. W. Reeves M.D. M. D. or other
Address: Westernport Md. Date signed: 9/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

07653

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cor[illegible] age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I. PLACE OF DEATH:

County Allegany

City or town Oldtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Oldtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles William Shanholtz

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Carrie Skelley

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Aug 5 1873

8. AGE:

Years	Months	Days	If less than one day
74	1	14	..... hrs. ..... min.

9. Birthplace Hampshire Co. W. Va.

(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business General Store

FATHER

12. Name Taylor Shanholtz

13. Birthplace W. Va.

MOTHER

14. Maiden name Lucinda Fairfax

15. Birthplace W. Va.

16. Informant Miss Bethel M. Shanholtz

Address Oldtown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 47 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. Sept. 22, 1947 (Date rec'd by registrar) Mrs C.A. Shanholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947 at 7 80 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 to Sept 19 1947 and that I last saw h... alive on Sept 11, 1947

Immediate cause of death	DURATION
Cerebral arteriosclerosis	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. D. Johnson Jr. M.D. M. D. or other

Address Cumberland Md. Date signed 9-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 07654

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Flintstone (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone (rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Star Route

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Price Shipley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Amanda Shipley

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1867

8. AGE:

Years	Months	Days	If less than one day
79	10	10	... hrs. ... min.

9. Birthplace: Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own farm

FATHER
12. Name: Bernard Shipley
13. Birthplace: Bedford Co., Pa.

MOTHER
14. Maiden name: Nancy Jay
15. Birthplace: Bedford Co. Pa

16. Informant: Harry Shipley
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 17, 1947 (month) (day) (year)

Cemetery or crematory: Fairview cemetery

Location: Bedford Co., Pa.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Sept. 15 1947 (Date rec'd by registrar) Mina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 14 1947, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 7 1947, to Sept. 14 1947 and that I last saw him alive on Sept. 14, 1947

Immediate cause of death	DURATION
Arteriosclerosis	?
Due to	
Due to	
Other conditions: Chronic Uremia, caused by albumen. (Include pregnancy within 3 months of death)	?

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of Injury ... Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other

Address: Little Orleans, Md. Date signed 9/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. RICHARD WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9-1a

07655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL, CUMBERLAND, MD.
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 WALNUT ST.,
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: LESTER W. SIMMONS

3.(b) Social Security Number: 217-10-1929

4. Sex: M
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: MARRIED
6.(b) Name of husband or wife: MRS. MARGUERITE SIMMONS
6.(c) If alive, give age: 37 years
7. Birth date of deceased (mo., day, yr.): JANUARY 19, 1900

8. AGE: Years 47 Months 8 Days 2 If less than one day ... hrs. ... min.

9. Birthplace: WEST VIRGINIA
(Town, county, and state)
10. Usual occupation: CELANESE - Spinning Dept
11. Industry or business

FATHER
12. Name: JOHN SIMMONS
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: JULIA Smith
15. Birthplace: W. Virginia

16. Informant: MARGUERITE SIMMONS
Address: 404 WALNUT ST., CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 1947 (month) (day) (year)
Cemetery or crematory: Maplewood Cemetery
Location: Elkins, W. Va
18. Funeral director: John J. Hafer
Address: Cumberland, md.

19. Sept. 23, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 21, 1947 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/19/47 19 , to 9/21/47 19
and that I last saw him alive on 9/21/47 19

Immediate cause of death	DURATION
Coronary thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: R. Williams M.D. M. D. or other
Address: Med. Bldg. Date signed: 9/21/47

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07656

136

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg R.D. No 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, institution, or street address where death occurred:

R.D. No 2 Frostburg, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. No 2 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm. Paul Spatzman

3.(b) Social Security Number 236-36-1676

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 21st, 1900

8. AGE: Years	Months	Days	If less than one day
47	0	3	..... hrs. ..... min.

9. Birthplace Frostburg Allegany Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business Arsenal Plant Pontiac

FATHER 12. Name Henry Spatzman

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Martha Lemmert

15. Birthplace Mt. Savage, Md.

16. Informant Frank Spatzman

Address 160 Oswald St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26th, 1947 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director David Baker

Address Frostburg, Md.

19. 9-24 1947 Mrs. Nancy N. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1946 to Sept 23 1947 and that I last saw him alive on Sept 20 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 to 4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W.M. Lane M.D. M. D. or other

Address Frostburg Md. Date signed 9-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

07657

CERTIFICATE OF DEATH

Reg. Diat. No. 14

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Waneta Virginia Stahlman

~~Waneta Virginia Stahlman~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Fe	White	Married

6.(b) Name of husband or wife Clyde E. Stahlman

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) April 9 1908

8. AGE: Years	Months	Days	If less than one day
39			hrs. min.

9. Birthplace Ellerslie (Town, county, and state) Md.

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name Clarence L Clark

13. Birthplace Ellerslie

MOTHER

14. Maiden name Harriet V. Yost

15. Birthplace Ellerslie

16. Informant Clyde Stahlman

Address Ellerslie

17. (Burial, cremation, or removal. Which?) Burial Date thereof 9/17/47 (month) (day) (year)

Cemetery ~~or crematory~~ Porter

Location Hyndman R.D. #1

16. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. (Date rec'd by registrar) Sept 16 47 J Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14, 1947 (M) 19 47 at 6 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 1943, to Sept 14 1947

and that I last saw h[illegible] alive on Sept 12/47 19

Immediate cause of death Chronic Myocarditis Rheumatic — DURATION

Due to Rheumatism

Due to Syphilis (Luetic)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D Kester M. D. or other

Address 120 Bedford St Date signed 9/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

07658

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, Institution, or street address where death occurred:

194 W. Main St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 194 W. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Bachman Steinla

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elmer Steinla

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 25th. 1881

8. AGE: Years: 65 | Months: 11 | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation: Home maker

11. Industry or business

FATHER

12. Name: Wm. Bachman

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Margaret Zink

15. Birthplace: Cumberland, Md.

16. Informant: Elmer Steinla

Address: 194 W. Main St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-27-1947 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob L. Kaufer

Address: Frostburg, Md.

19. 9-26 1947 Mrs. Nancy V. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to Sept. 24 1947.

and that I last saw her alive on September 1947.

Immediate cause of death: Hypertension Cardio-Vascular Disease

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or Town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Diehl M.D. M. D. or other

Address: Frostburg, Md. Date signed 9/26/47

Within corporate limits

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

B

67659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 6 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County HAMPSHIRE

City or town AUGUSTA

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME CAROLE ANN TUTWILER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 10, 1947

8. AGE: Years | Months: 3 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name CLYDE O. TUTWILER

13. Birthplace WEST VIRGINIA

MOTHER

14. Maiden name DAUGHERTY, FLOE

15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 20, 1947 (month) (day) (year)

Cemetery or crematory Augusta Cem.

Location Augusta, W. Va.

18. Funeral director W. J. McKee

Address Augusta, W. Va.

19. Sept. 19, 1947 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 18 1947 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1947, to Sept 18 1947

and that I last saw h.. alive on Sept 18 1947

	DURATION
Immediate cause of death: Pneumonia	2 wks
Due to: Prematurity	3 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. L. Eliason M.D. M. D. or other

Address 126 Union St Cumberland Md Date signed 9/19/47

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

DR. CAWLEY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45a

07660

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RT. #4 CHRISTIE RD.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: MR. ARGYLE TWIGG

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MARY DIETZ

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): MARCH 16, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	26	..... hrs. ..... min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: UNABLE TO WORK

11. Industry or business:

FATHER — 12. Name: Andrew Twigg

FATHER — 13. Birthplace: Parkersburg, W. Va.

MOTHER — 14. Maiden name: Nancy Backus

MOTHER — 15. Birthplace: Parkersburg, W. Va.

16. Informant: MRS. MARY TWIGG

Address: RT. #4 CHRISTIE RD. CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 14, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cemetery

Location: Cumberland, Md.

18. Funeral director: John F. Hafer

Address: Cumberland, Md.

19. Sept. 13, 1947 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 12, 1947 19.... at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 27 19 46, to SEPT 11 19 47

and that I last saw h. i. m. alive on SEPT 11, 19 47

Immediate cause of death	DURATION
CARCINOMA FACIAL GLANDS	
Due to PRIMARY LESION ON LIP	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Earle M.D. M. D. or other

Address: Memorial Hosp. Cumberland Date signed: Sept. 12 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

07661

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 619 Henderson [redacted] Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Henderson [redacted] Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME James E Twigg

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed.

6.(b) Name of husband or wife Ida Kinsel Twigg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5 1875

8. AGE:

Years	Months	Days	If less than one day
72	5	2	..... hrs. ..... min.

9. Birthplace near Oldtown Md.
(Town, county, and state)

10. Usual occupation Concrete worker.

11. Industry or business General.

FATHER
12. Name Aden Twigg
13. Birthplace Md.

MOTHER
14. Maiden name Jemia —
15. Birthplace Md.

16. Informant Thurman Twigg

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10 47 (month) (day) (year)

Cemetery or crematory Gion Memorial Cem

Location Route Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Sept. 9 1947 W. L. Lantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1947 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Sept 7 1947 and that I last saw h[redacted] alive on Sept 6 1947

Immediate cause of death	DURATION
Cardio-renal	
Due to Cold	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bayley Hunter M.D.
M. D. or other

Address Cumberland Md. Date signed 9/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926

07663 4

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Months

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 316 WAVERLEY TERRACE,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME SUSAN D. TWIGG

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 25, 1946

8. AGE:

Years	Months	Days	If less than one day
1	7	0	hrs. min.

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name EDWARD TWIGG
13. Birthplace MARYLAND

MOTHER
14. Maiden name MARY E. WEBER
15. Birthplace MARYLAND

16. Informant Edward P. Twigg
Address 316 Waverley Terrace, Cumberland, Md

17. Burial Date thereof Sept 27 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafner

Address Cumberland, Md.

19. Sept. 27 19 47 W. L. Fauntz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 25 19 47 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-1- 19 46, to 9-25 19 47 and that I last saw h.er alive on Sept. 9 19 47

Immediate cause of death	DURATION
Pulmonary Stenosis	10 mos.
Due to Congenital?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Pulmonary Stenosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Eliason M.D.
M. D. or other

Address Cumberland Md Date signed Sept 27 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

936

07663

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74-6-22

Hospital, institution, or street address where death occurred: 529 Fayette St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Mary B Wallace

3.(b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Theodore Wallace.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 14 1873

8. AGE: Years: 74 | Months: 6 | Days: 23 | If less than one day: ..... hrs. ..... min.

8. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER — 12. Name: John A Gaetz

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Bernard

MOTHER — 15. Birthplace: Germany.

16. Informant: Theodore A Wallace

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10 47 (month) (day) (year)

Cemetery or crematory: St Peter & Paul's Cem.

Location: Cumberland

18. Funeral director: Louis Stein Sons.

Address: Cumberland.

19. Sept. 9 1947 (Date rec'd by registrar) W.L. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/5/47 19.. to 9/6/47 19.. and that I last saw h.. alive on 9/6/47 19..

	DURATION
Immediate cause of death: Myocardial Failure	2 days
Due to: Chr Myocarditis	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury: ..... Injured at work?

23. SIGNATURE: W.L. Williams M.D. M. D. or other

Address: Med Bldg Date signed: 9/8/47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07664 St. Mc Lane

938

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jonas E. Wampler

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Anna Wampler

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) July 25 — 1867

8. AGE: Years	Months	Days	If less than one day
80	1	16	..... hrs. ..... min.

9. Birthplace Indiana (Town, county, and state)

10. Usual occupation retired farmer

11. Industry or business

FATHER 12. Name Daniel Wampler

13. Birthplace Virginia

MOTHER 14. Maiden name Lufratia Weitzell

15. Birthplace Maryland

16. Informant Floyd Wampler

Address Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14-1947 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart Md

18. Funeral director J. R. Durst

Address Frostburg, Md.

19. 9-15 1947 Mrs. Nancy V. Rose (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1947 at 9 30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 1947 to Sept 10 1947

and that I last saw h.m. alive on Sept 11 1947

Immediate cause of death	DURATION
Cerebral Embolism	1 Day
Due to Chr Myocarditis	Several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W M Lane M.D. M. D. or other

Address Frostburg Md Date signed 9-12-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

56 b

07665

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Verd Grace "Swain" Warnick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Gordon Warnick

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): March 6, 1907

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
40	6	21		

9. Birthplace: Little Orleans, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: James I. Swain

13. Birthplace: Little Orleans, Md.

MOTHER

14. Maiden name: Annie Trudy

15. Birthplace: ?

16. Informant: Gordon Warnick

Address: Cresaptown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: September 30, 1947 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Maryland

18. Funeral director: John J. Hafer

Address: Cumberland, Maryland.

19. Sept. 30, 1947 (Date rec'd by registrar) W. R. Fauley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27, 1947, 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 19.47 to Sept. 27 19.47

and that I last saw h er alive on Sept. 27 19.47

Immediate cause of death	DURATION
Coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Tobacco uterus.

Date of op. Sept. 1943

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John R. Rozum, M. D. or other

Address: Cumberland, Md. Date signed: 9/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

07666

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157 b B

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. Va. County Mineral

City or town Kaysar
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Rita Christine Weaver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	3	... hrs. ... min.

9. Birthplace Kayser, Mineral Co., W. Va.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Manzel Weaver
13. Birthplace Lillian, W. Va.

MOTHER
14. Maiden name Edna Van Meter
15. Birthplace Maysville, W. Va.

16. Informant Manzel Weaver
Address Rt 2, Kayser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 28, 1947 (month) (day) (year)

Cemetery or crematory Stump Cemetery

Location near Petersburg, W. Va.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Sept. 28, 1947 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947, at 9:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 1947 to Sept 27 1947.

and that I last saw him alive on Sept 26 1947

Immediate cause of death	DURATION
Born Deformed	8
Spina Bifida	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W. R. Frantz M.D.
M. D. or other

Address 337 Baltimore Ave Date signed 9/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95 b 11

07667

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospitel, Institution, or etreet address where death occurred:

241 Cromwell St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 241 Cromwell St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ERNEST LYNN WILTISON

3.(b) Social Security Number - - - - - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	~~Married~~ Single

6.(b) Name of husband or wife - - - - - - - - - - - - -

6.(c) If alive, give age - - -

7. Birth dete of deceeeed (mo., day, yr.) February 21, 1934

8. AGE: Yeere	Monthe	Days	If lese than one day
13	6	28	hrs. min.

9. Birthplace: Luke, Allegany, Maryland (Town, county, and state)

10. Usual occupetion: Student

11. Induetry or buelnese: Grade school

FATHER

12. Name: Jacob Lynn Wiltison

13. Birthplace: Burlington, W. Va.

MOTHER

14. Maiden name: Virginia Hitt

15. Birthplace: Luke

16. Informant: Jacob L. Wiltison

Address: Luke, Maryland

17. (Burial, cremation, or removal. Which?) Burial Dete thereof (month) (day) (year) Sept 21, 1947

Cometory or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Maryland

19. Sept. 21 19 47 [illegible] Registrar

(Date re d by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 19 47 at 8:15 a M

21. I CERTIFY that death occurred on the dato ebove etated: that I ettended deceaeed from July 20, 1946 19 to Sep 19 19 47 and thet I last saw him alive on Sep 19, 1947 19

	DURATION
Immediate cause of death: Cerebral Embolism	5 hrs
Due to: Rheumatic heart disease	4 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operatioos

Date of op.

Aotopsy results

PHYSICIAN: Please underline the cnose to which death should be charged statistically.

22. VIOLENCE: If doath was due to external causes, fill in the following:

Accident, suicide, or homicide Dato of

Where did injury occur? (City or town) (County) (State)

Injured et home, ferm, industry, public piece (where?)

Means of injury Injured at work?

23. SIGNATURE: James Allen Wiltison Jr MD M. D. or other

Address: Piedmont W. Va. Date signed: 9-20-47

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